Therapeutic Restraint Flow Sheet

CCS CORRECT CARE SOLUTIONS

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

ALLERGIES:				
Date:	Time Initiated:	Initial Pulse:	Respiration:	Blood Pressure:

Place a "√" in the box if done, leave the box blank if not done or place the letter T, R, O and I in the box.

Nurse Initials:									
Time:									
ASSESSMENT									
Extremity restraints checked X 4									
Extremity pulses checked X 4									
Chest restraint checked									
ROM to all extremities									
BEHAVIOR									
Cooperative									
Uncooperative									
Awake and quiet									
Resting/Sleeping									
Agitated									
Verbal threats									
INTAKE AND OUTPUT									
% of meal eaten Refused = **R**									
Fluids taken = **T** Refused = **R**									
Urine Toileting offered = **O** Incontinent = **I**									
BM Toileting offered = **O** Incontinent = **I**									

VITALS									
Time									
Pulse									
Respiration									
Blood Pressure									
Fluid Intake									
Output Urine									
Output Bowel									

Comments (date and time each entry): _____

Nurse Signature	Initials	Nurse Signature	Initials	Nurse Signature	Initials

D2512DP14792PNXN